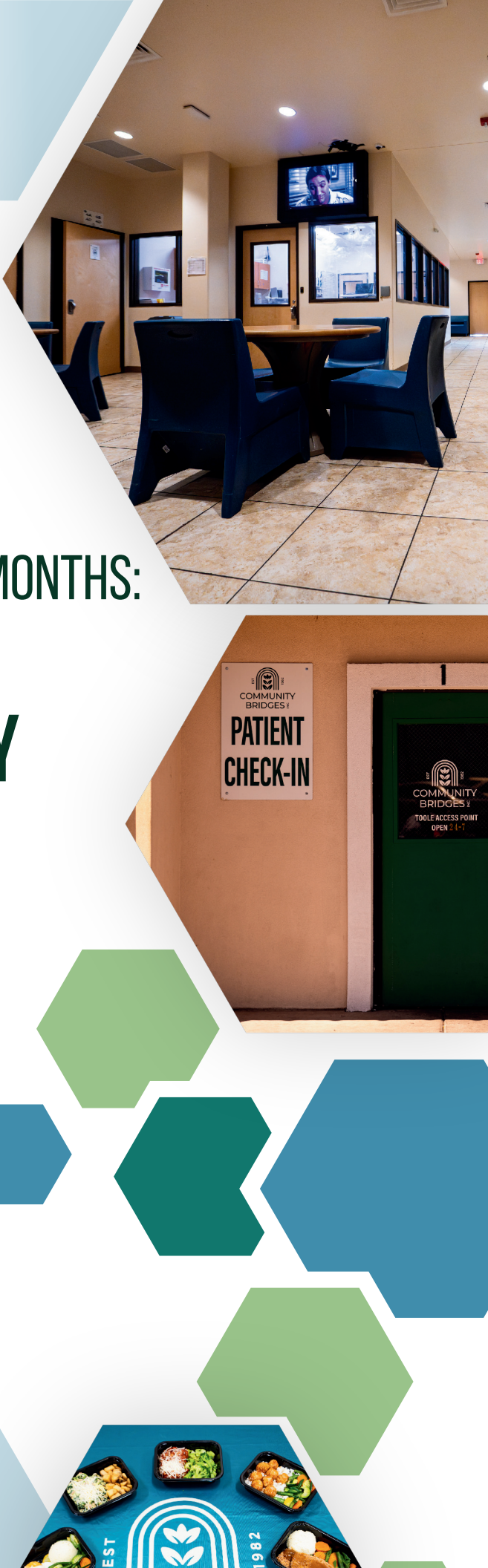




THE SAFR CENTER PILOT AT SIX MONTHS: **IMPLEMENTATION PROGRESS AND EARLY FINDINGS**

January - June 2026

Prepared by:
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August, 2026



College of Agriculture,
Life & Environmental
Sciences

Table of Contents

Executive Summary	1
Introduction: The SAFR Center's Origin and Six-Month Pilot	3
Patient Overview and Experience	
Patient Demographics and Social Determinants of Health	4
Length of Stay	7
Patient Feedback	10
Patients with Pets	11
Progress Towards the SAFR Center's Goals	
SAFR Goal 1: Reducing Acute Health Harms	13
SAFR Goal 2: Decreasing Law Enforcement Involvement.....	16
SAFR Goal 3: Mitigating Long-Term Consequences of Substance Use.....	19
Quality Improvement	24
Recommendations.....	25
Conclusion: The Year Ahead	28
References.....	29
Appendix A: PRAPARE Screening Tool.....	30
Appendix B: Patient Satisfaction Survey	33
Appendix C: Police Officer Survey	35

Acronyms Used in this Report

AHCCCS – Arizona Health Care Cost Containment System

AMA – Against Medical Advice

CBI – Community Bridges, Incorporated

CORE – Community Outreach Resource and Education

CPI – Crisis Prevention Intervention

EHR – Electronic Health Record

EMS – Emergency Medical Services

LOS – Length of Stay

MOUD – Medications for Opioid Use Disorder

ODU – Opioid Use Disorder

PACC – Pima Animal Care Center

PRAPARE – Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences

QI – Quality Improvement

SAFR – Sobering Alternative for Recovery

SDoH – Social Determinants of Health

TPD – Tucson Police Department

UDS – Urinary Drug Screen

Executive Summary

Pima County's Sobering Alternative for Recovery (SAFR) Center opened in January 2026 as the county's first sobering center, operated by Community Bridges, Inc. (CBI) with opioid litigation settlement funds. The 15-bed, 24/7 facility provides up to 96 hours of monitoring, clinical assessment, medications for opioid use disorder (MOUD), group counseling and support, and referrals for individuals experiencing acute intoxication. This report, prepared by the University of Arizona RISE team as SAFR's external evaluator, presents findings from the Center's six-month (January–June 2026) pilot. Findings are organized around three of SAFR's key goals: 1) reduce health harms for intoxicated individuals, 2) decrease related law enforcement burden, and 3) mitigate the long-term consequences among SAFR patients.

PATIENT POPULATION AND EXPERIENCE

The SAFR Center served an average of 58 patients monthly, most of them White, Non-Hispanic/Latino, male, and between 25-54 years old; 81% had Title XIX insurance. Screening revealed extensive social needs: 86% of patients had no or unstable housing, 99% were unemployed, and 63% had missed medical appointments or work due to lack of transportation. Patients rated their SAFR experience positively overall, averaging 4.6 to 4.8 out of 5 across six survey measures. Patients most often cited staff warmth, meals, and group sessions as benefits. The median patient stay settled near 45 hours by June. Pet accommodation improved through new guidance and policies, vaccination partnerships, and dedicated pet spaces. Post-discharge options for patients with pets remained limited.

PROGRESS TOWARD SAFR'S GOALS

Reducing acute health harms. Fifty-one percent of patients were diagnosed with opioid use disorder (OUD), and fentanyl was the most commonly detected opiate. Forty-two percent of patients who tested positive for opioids initiated buprenorphine at SAFR, while continuation rates among those already on buprenorphine at intake declined over the pilot, from 100% in the first three months to 15% by June (although earlier rates reflected small samples). Triage time and naloxone distribution were inconsistently documented during the pilot. CBI has begun addressing these gaps through additional staff training and documentation practices.

Decreasing law enforcement involvement. Criminal Justice referrals made up a small share of documented intake sources, with most patients internally transferred from CBI's 23-Hour Crisis Unit. Feedback from the Tucson Police Department's Community Outreach Resource and Education (TPD CORE) unit affirmed SAFR's value beyond formal deflection, citing its hours, pet acceptance, and low-barrier intake. The unit also noted that their SAFR referral numbers were higher than CBI's data, a discrepancy warranting further exploration. Only three officer drop-off surveys were submitted during the pilot, further limiting this data.

Mitigating long term consequences of substance use. Seventy percent of patients completed their SAFR stay, with most receiving treatment referrals to CBI's outpatient clinics. Referrals to Medical and Behavioral Health partners, particularly to SAFR subcontractor CODAC, increased steadily over the period. Nineteen patients utilized CODAC's outpatient post-discharge care, and the four patients who initiated MOUD remained engaged at 30 and 60 days. Barriers to sustained CODAC engagement included unstable housing, continued substance use exposure, and phone access challenges.

RECOMMENDATIONS FOR THE YEAR AHEAD

DATA & DOCUMENTATION

1. **STRENGTHEN INTAKE REFERRAL REPORTING.** Coordinate with TPD's CORE unit on shared referral metrics to more accurately track SAFR's deflection impact.

PATIENT CARE

2. **CLARIFY DISCHARGE DOCUMENTATION.** Document discharges more precisely so that the Family/Friend category, now 18% of all treatment referrals, is no longer used for patients leaving without a verified referral.
3. **EXPAND TREATMENT OPTIONS FOR PATIENTS WITH PETS.** Explore additional options for patients with pets, including within CBI's internal referral network.
4. **SUSTAIN POST-DISCHARGE CONTINUITY OF CARE.** Strengthen post-discharge support for medication treatment, housing, and employment during the vulnerable period after discharge.

COMMUNITY PARTNERSHIPS

5. **BROADEN THE COMMUNITY PARTNER NETWORK.** Broaden the range of community partners who will refer individuals to SAFR as well as provide post-discharge care.

CONCLUSION

Over six months, SAFR moved from an accelerated launch to a program with a clearer operational rhythm. Patient satisfaction was high, while data and stakeholder feedback showed a program still resolving gaps in data coordination, documentation, and support for patients with pets or complex social needs. In June, the Pima County Board of Supervisors approved a one-year pilot extension. This time will allow SAFR to continue building toward its key goals and address identified gaps while remaining an important, low-barrier resource for acute substance use care in Pima County.

Introduction: The SAFR Center's Origin & Six Month Pilot

Pima County's substance use crisis, driven centrally by fentanyl and other opioids, has strained emergency departments, jails, and first responders for over a decade. Individuals experiencing acute intoxication have historically had few options beyond the emergency room or jail, neither of which was designed to address the complex needs that typically accompany a crisis episode.

In January 2026, CBI opened the SAFR Center in response to this gap, using \$1.8 million in opioid litigation settlement funds. As the county's first sobering center, the SAFR Center operates as a 15-bed, 24/7 low-barrier deflection point for law enforcement and community partners, offering short-term medical monitoring, clinical assessment, MOUD, group counselling, peer support, and referrals to ongoing care.

This Endpoint Report, prepared by the University of Arizona RISE team as the SAFR Center's external evaluator, presents findings from the first six-month pilot period: January through June 2026. It builds on the [Midpoint Report](#) issued in April, which reflected the program's first three months of operation. This report extends that analysis with a larger patient sample (322 unique patients across 346 admissions), a greater uptake in social determinants of health (SDoH) screening,

and new data streams including CODAC's longer term patient outcomes and feedback from the TPD CORE Unit.

Together, these sources provide a fuller account on the extent to which the SAFR Center has made progress on three of its founding goals: 1) reduce acute health harms through medical monitoring and harm reduction, 2) decrease law enforcement detentions and jail bookings through deflection, and 3) mitigate the long-term consequences of criminalization by connecting patients to housing, treatment, and other social supports. Implementation of the Center's fourth goal, to reduce burden on emergency medical services (EMS) for those experiencing acute intoxication, remains nascent and will be evaluated in future reports.

At the end of June, the Pima County Board of Supervisors approved a one-year extension of the SAFR Center's pilot operations, with continued support from the county's opioid settlement funds. The sections that follow examine who the SAFR Center has served, how care has unfolded, and where operational progress stands after six months to support continued advancement of the Center's sobering care model in the year ahead.

"The [SAFR] Center helps communities become safer, while providing folks a safe space with a bed, shower, meal, and a phone to connect with their family."

-SAFR Staff

Patient Overview and Experience

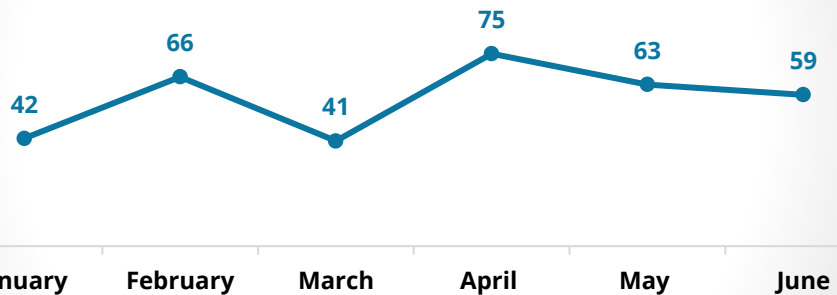
322

UNIQUE PATIENTS FROM
JANUARY THROUGH JUNE

346

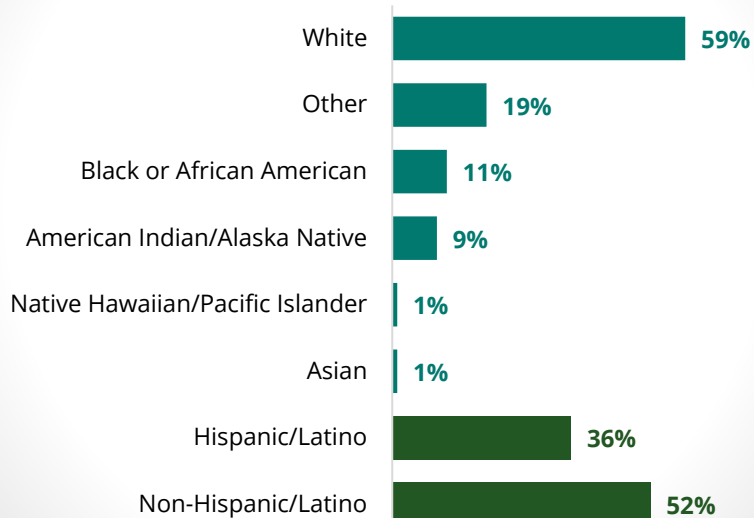
NON-UNIQUE PATIENTS
FROM
JANUARY THROUGH JUNE

In the first six months of operation, the SAFR Center received an average of 58 monthly patients.

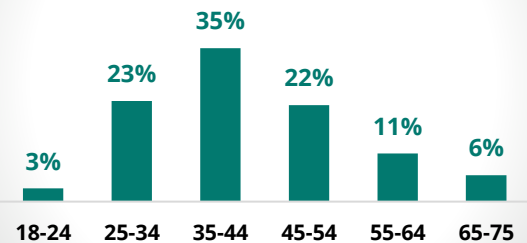


Most patients were White and Non-Hispanic/Latino.

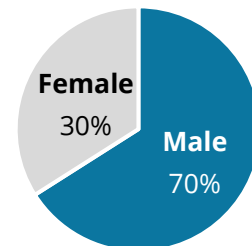
Ethnicity data was incomplete due to documentation gaps or patients declining to provide this information.



Most patients were 25-54 years old.



Most patients were male.



81%

OF PATIENTS HAD TITLE XIX
INSURANCE

4%

OF PATIENTS HAD A SEVERE
MENTAL ILLNESS (SMI)

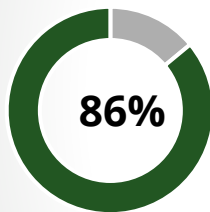
2%

OF PATIENTS WERE
VETERANS

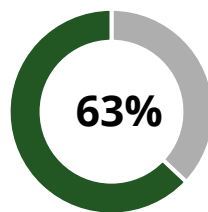
Patients arrived at the SAFR Center with health and social needs. Upon admission, patients were screened with the Protocol for Responding to and Assessing Patient's Assets, Risks, and Experiences (PRAPARE) assessment (**Appendix A**) between March

and June (n=177). Findings highlighted the range of needs among various social determinants of health (SDoH) across patients' housing and transportation, economic stability, education, and social context.

HOUSING AND TRANSPORTATION

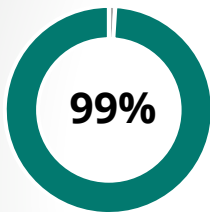


of patients had **no or unstable housing**

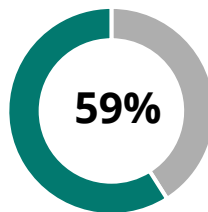


of patients had missed medical appointments, meetings, or work due to **lack of transportation**

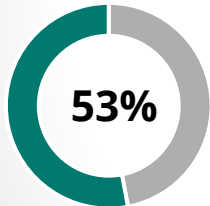
ECONOMIC STABILITY



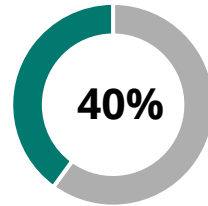
of patients were **unemployed**



of patients were unable to get **food when needed in the past year**

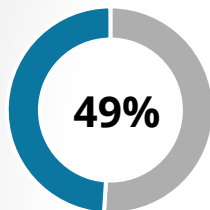


of patients were unable to get **clothing in the past year**

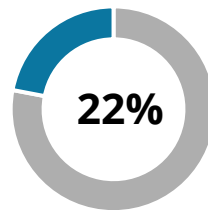


of patients were unable to get a **phone when needed in the past year**

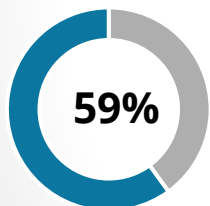
EDUCATION, SOCIAL, AND COMMUNITY CONTEXT



of patients had less than a **high school degree**



of patients reported being in the **criminal justice system in the past year**



of patients reported talking to others **less than once a week**

Additional exploratory analyses were conducted to better understand patients' SDoH.¹ No significant relationships between patient demographic groups were found among PRAPARE items. However, when relationships between multiple PRAPARE measures were examined within gender groups, several significant patterns emerged:

AGE OF MALES AND SOCIAL CONNECTION. There was a significant negative relationship between the age of males and social connection ($\rho = -0.25$, $p \leq 0.05$, small effect size) (**Figure 1**). This finding suggests that social connection opportunities during patients' stay at SAFR, such as group sessions, may be particularly valuable for older patients. Additionally, limited social connection may indicate that older male patients have fewer natural supports to rely on after discharge from the SAFR Center.

STRESS AND FOOD ACCESS AMONG MALES. Among males, higher stress levels were associated with reduced food access in the past year ($\rho = 0.24$, $p \leq 0.05$, small effect size). This finding highlights the potential benefit of connecting patients, with particular attention to male patients reporting food insecurity, with resources such as food assistance, food benefits enrollment, or community food programs during discharge planning.

STRESS AND TRANSPORTATION AMONG MALES.

Higher stress levels among male patients were significantly associated with transportation barriers to accessing medical care ($\rho = 0.25$, $p \leq 0.05$, small effect size) and non-medical needs ($\rho = 0.24$, $p \leq 0.05$, small effect size). This suggests that male patients' stress related to transportation gaps may create unique barriers post-discharge. Although the SAFR Center offers transportation to community referral sites, transportation may remain a barrier to continued care and resource engagement. Further exploration is needed to better understand the relationship between stress and transportation barriers among male patients.

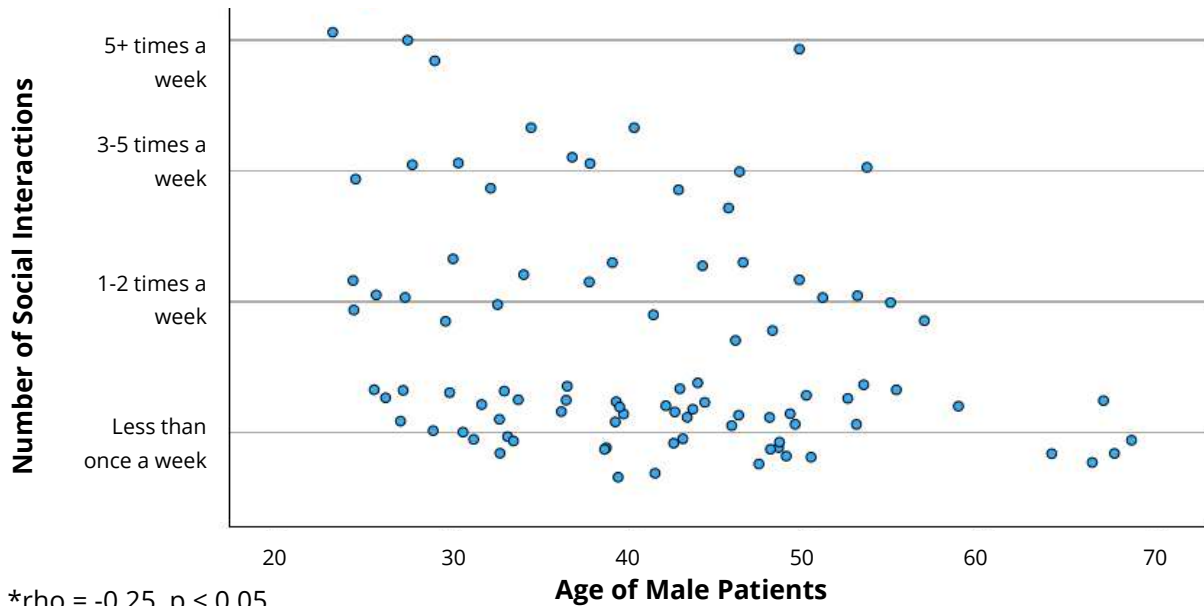
STRESS AND EDUCATION AMONG FEMALES.

Among all patients with lower educational attainment, females reported more stress than males ($p \leq 0.05$, $d = 0.50$, medium effect size). These women within the SAFR patient population may be in particular need of social services that support their mental health at discharge.

As patient numbers increase, future analyses will also explore differences in these measures between one-time patients and those who have repeat encounters at the SAFR Center.

¹ Spearman's correlation was used for correlation analyses. The correlation coefficient itself is a measure of the relationship's effect size: small effect (0.1 - 0.29), medium effect (0.3 - 0.49), large effect (0.5+). The Mann-Whitney U test and Kruskal Wallis tests were used to measure the difference in medians between different factors and PRAPARE items. The magnitude of difference was reported with Cohen's d by converting non-parametric effect sizes: small effect (0.15 - 0.44), medium effect (0.45 - 0.79), large effect (0.80+).

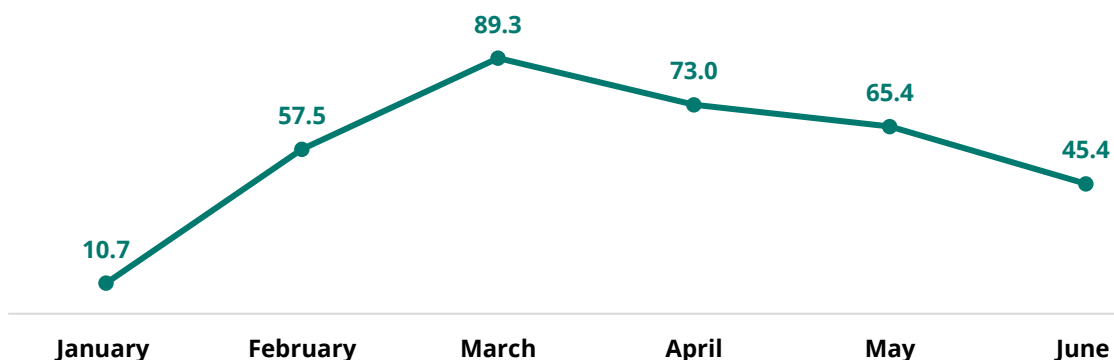
1. An increase in the age of male patients (n=94) was associated with fewer social interactions.*



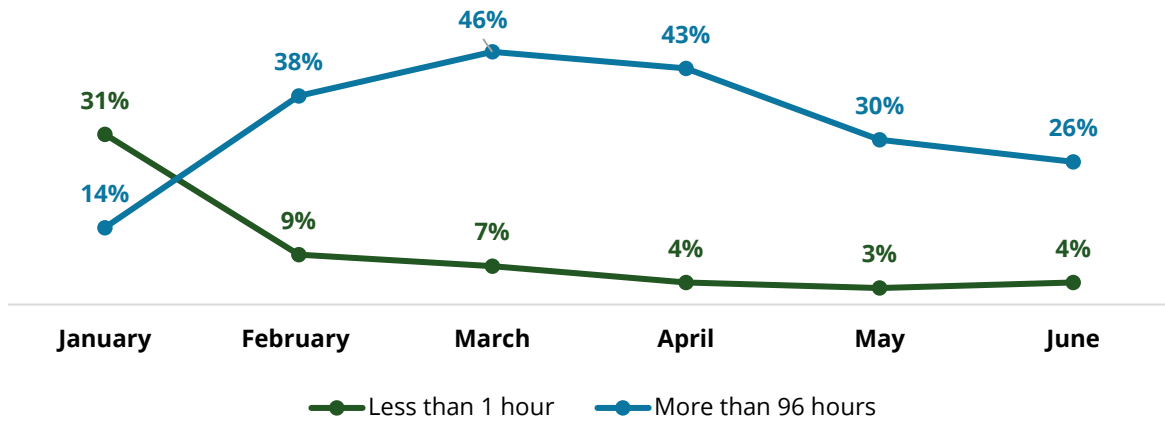
Patient Length of Stay (LOS). The median LOS for patients increased between January to March, then gradually declined through June. (Figure 2). By June, the median LOS was about half the maximum target stay of 96 hours. Accordingly, the percent of patients who left after less than one hour or

stayed longer than 96 hours declined (Figure 3). These shifts in LOS may continue to evolve in the coming months; discharge placements for patients with pets remain challenging and federal funding for patients needing a shelter bed dwindles as the year progresses.

2. Patients' median length of stay (in hours) at the SAFR Center increased from January-March, then declined through June (n=346).



3. The percent of patients staying at the SAFR Center longer than 96 hours peaked in March, then decreased through June (n=346). The percent of patients staying less than one hour declined from January's peak.



Factors Impacting Patient LOS. Additional analyses were completed to explore factors associated with patients' LOS during the first six months of operation.² No statistically significant differences in the median LOS were observed across racial groups, gender, or intake referral type.

LOS AND AGE. Results showed a significant positive relationship between age and LOS ($\rho = 0.13$, $p \leq 0.05$, small effect size), suggesting that an increase in the age of SAFR patients was associated with a longer stay. Further analyses showed a significant positive relationship among male patients ($\rho = 0.14$, $p \leq 0.05$, small effect size), meaning that older male patients tended to have longer lengths of stay compared to

younger male patients (Figure 4). In addition, a significant positive relationship was observed between age and LOS among White patients only ($\rho = 0.17$, $p \leq 0.05$, small effect size) (Figure 5). Together, these relationships indicate that White male patients drove the strength of association between LOS and patient age.

Analyses also identified several associations between patients' responses on PRAPARE items and LOS.

LOS AND EDUCATION. Patients with a high school diploma or GED had a significantly longer LOS than those who had not completed high school ($p \leq 0.01$, $d = 0.53$, medium effect size). While level of education itself may not explain differences in LOS,

² Spearman's correlation was used for correlation analyses. The correlation coefficient itself is a measure of the relationship's effect size: small effect (0.1 - 0.29), medium effect (0.3 - 0.49), large effect (0.5+). The Mann-Whitney U test and Kruskal Wallis tests were used to measure the difference in medians between different factors and LOS. The magnitude of difference was reported with Cohen's d by converting non-parametric effect sizes: small effect (0.15 - 0.44), medium effect (0.45 - 0.79), large effect (0.80+).

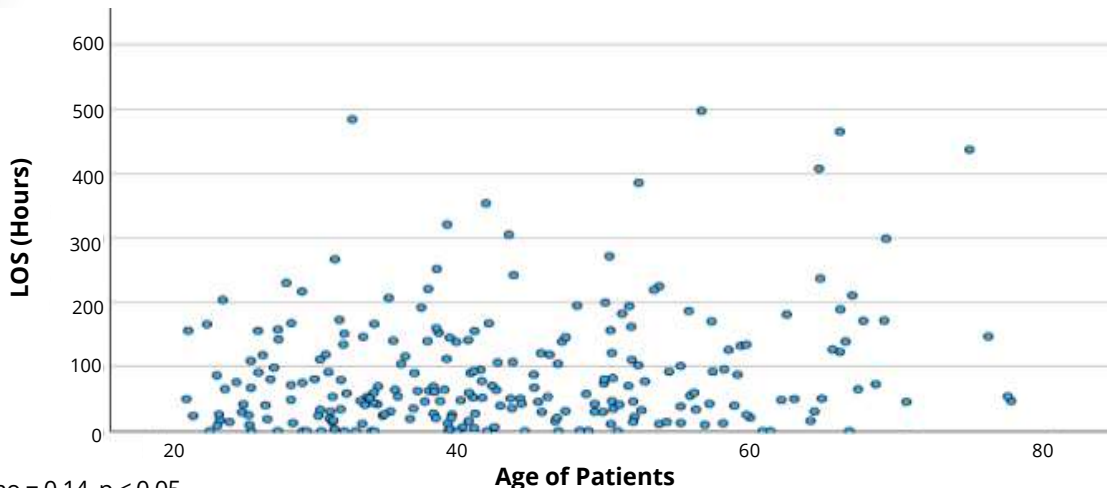
educational attainment may reflect differences in employment opportunities, income, health literacy, access to resources, or ability to navigate healthcare and social service systems.

LOS AND FOOD/CLOTHING NEEDS. LOS was negatively associated with both the inability to get food ($\rho = -0.21$, $p \leq 0.05$, small effect size) or clothing ($\rho = -0.23$, $p \leq 0.01$, small effect size), in the past year. This indicates that patients reporting food or clothing insecurity in the past year tended to have shorter lengths of stay at the SAFR Center.

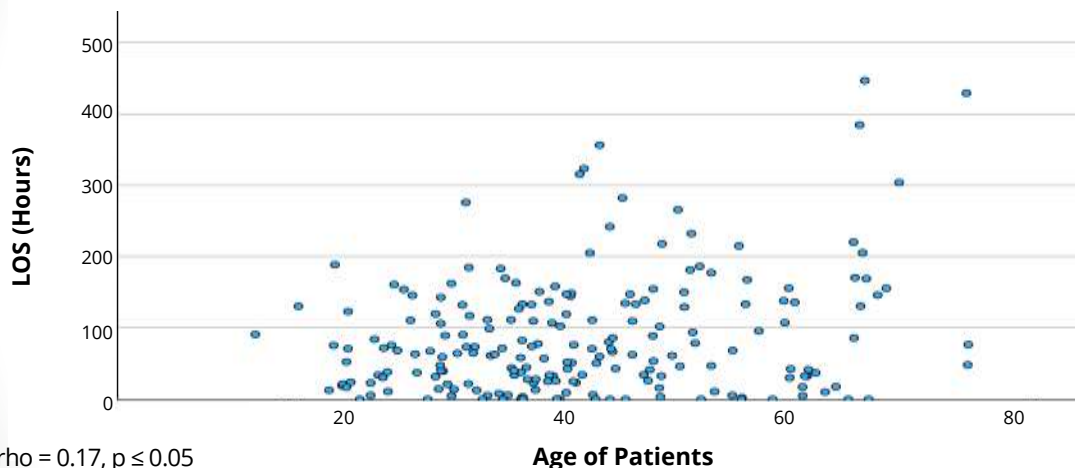
LOS AND TRANSPORTATION. A lack of medical ($\rho = -0.06$) and non-medical ($\rho = -0.09$) transportation showed a weak negative association with LOS (and were not statistically significant), meaning that the impact of patients' lack of transportation access on LOS was inconclusive.

Collectively, these findings suggest that LOS may be shaped by patients' broader social context, highlighting the importance of tailored care and discharge planning throughout patients' time at the SAFR Center.

4. Older male patients tended to have a longer stay (n=240 male patients).*



5. Older White patients tended to have a longer stay (n=204 White patients).*



Patient Feedback. Between March and June, patients were invited to complete a brief feedback survey (**Appendix B**) in English to share insights on their experiences at the SAFR Center. The survey included six rank-based measures of satisfaction, along with one open-ended question asking what patients liked about the SAFR Center. Overall, of the 53% of patients who completed the

survey between March and June, most had positive attitudes related to their experiences. Patients especially highlighted SAFR staff, group sessions, and the ability to eat, rest, and recover in a safe space. Some patients also noted concerns around staff capacity to assist them, restroom cleanliness, and inadequate food portions.

Between March-June, patients who completed a survey generally had a positive attitude towards their experience at the SAFR Center (n=127). Patients rated each item using a 1 (Strongly Disagree) to 5 (Strongly Agree) scale.



41% of patients noted the helpful and friendly care SAFR Center staff provided.

"I liked the patience all the staff had. I appreciated everything and how fast they made things happen for me."

12% of patients highlighted the meals provided at the SAFR Center.

"They [were] attentive to your health and well-being...thank you very much for the excellent experience and the food."

6% of patients highlighted the group sessions led by peer support specialists.

"The groups were very helpful plus the staff [were] friendly and helped me on my recovery journey."

6% of patients noted the comfort and sense of safety provided by the SAFR Center.

"CBI kept me safe and gave me the environment and stability that I needed."

3% of patients noted the ability to meet and receive support from others seeking care.

"I enjoyed the people and community I've made during my stay the most."

Patients with Pets. Throughout the pilot period, SAFR staff have emphasized the unique importance of the pet care services offered by the SAFR Center. Progress narratives from SAFR staff and external partners, summarized in the [Midpoint Report](#), highlighted early challenges for accepting patients with pets. Over time, facility operations, policies, and community partnerships evolved to better support patients seeking care with their pets. Despite these improvements, several challenges remain and may require continued attention beyond the pilot period.

18 pets were brought to the SAFR Center from January through June

17 dogs were brought to the SAFR Center from January through June

1 cat was brought to the SAFR Center from January through June

PET CARE HIGHLIGHTS FROM JANUARY THROUGH JUNE



GUIDANCE POLICIES. Formal guidance for pet care was implemented, outlining requirements for vaccinations, the four pet facility limit, and the two pet limit per patient.



VACCINATIONS. SAFR staff coordinate with the Pima Animal Care Center (PACC), ensuring pets have access to vaccinations during PACC's hours of operation.



PET RESOURCES. Four crates were purchased to safely house pets with their owners, as well as leashes. A pet waste bag dispensing station and a dog run were also installed outside the facility.



REFERRAL PARTNERSHIPS. Established partnerships with treatment programs locally and in Phoenix have been a source of referrals for patients with pets.



STAFF ADAPTABILITY. Staff with pet-related allergies were relocated to other CBI sites. As this occurred, new CBI staff were trained on SAFR-specific protocols and documentation processes.



DATA QUALITY. CBI leaders integrated a data field into the electronic health record (EHR) system to track pet counts.

PET CARE CHALLENGES FROM JANUARY THROUGH JUNE



VACCINATIONS. When patients arrive at SAFR with pets outside PACC's open hours, admission is delayed until their pets receive the required vaccinations. In these situations, staff work with other agencies to arrange vaccinations, but availability remains constrained outside of normal operating hours.



REFERRAL SITES. SAFR staff consistently noted a significant challenge in supporting continuity of care due to the limited availability of pet-friendly treatment or shelter options after discharge. This barrier is especially challenging for patients with cats.



DATA QUALITY. Improvements are in progress for regular reporting of pet vaccinations, certifications, and spay/neuter information.

Patient Comfort and Accessibility. Beyond pet accommodation, the SAFR Center provides services that enhance patient comfort and level of care:



SMOKING BREAKS. Patients are permitted to have cigarettes and take scheduled outdoor smoking breaks throughout the day.

*"Being able to smoke here is huge. Not all detoxification centers allow people to smoke. **When [patients] are giving up everything, they need to be able to smoke.**"*

-SAFR Staff



GROUP SESSIONS, which offer skill-building (such as relapse prevention and understanding and coping with triggers) and peer support.

*"Patients love groups. **They relate to peers who have [similar] experiences, and they can talk about them without judgement.** They get social connection and something engaging."*

-SAFR Staff



STORAGE. A secure area for belongings allows patients to enter care knowing their possessions will still be there when they leave SAFR.



96-HOUR CARE. While many sobering facilities nationally provide care for up to 24 hours, SAFR offers up to 96 hours of care. This allows patients time to stabilize, initiate or continue MOUD, and consider treatment opportunities.

SAFR Goal 1: Reduce acute health harms and improve safety for intoxicated individuals through medical monitoring, harm reduction interventions, and prevention of intoxication-related injuries or complications.

After a patient is admitted to the SAFR Center, they receive a series of formal clinical assessments, including a psychiatric evaluation, urinary drug screen (UDS), screening for opioid use disorder (OUD), and assessments for other substance use and/or behavioral health diagnoses.

UDS and Clinical Evaluation for Opioid Use.

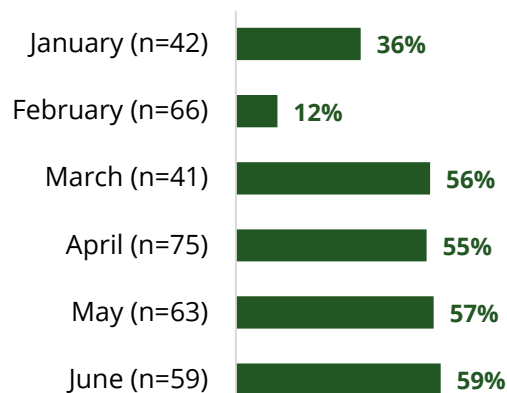
Among all patients, 51% were diagnosed with OUD. Of patients diagnosed with OUD (n=178), 62% had a co-occurring substance use disorder, primarily Amphetamine Use Disorder (46%). All patients were screened via UDS for opiates (Figure 6) and other substances. Of patients who screened positive for opiates (n = 158), fentanyl was the most detected via UDS (Figure 7).

MOUD Initiation and Continuation.

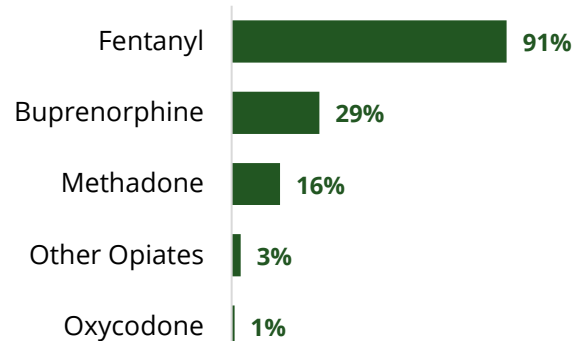
During their stay, patients may be offered Medications for Opioid Use Disorder (MOUD), specifically buprenorphine, for stabilization to support their short- and longer-term care needs (Figure 8). During the pilot period, 42% of patients who tested positive for opioids initiated buprenorphine; 47% of patients who screened positive for buprenorphine at the time of intake continued with treatment at the SAFR Center. The proportion of patients who continued buprenorphine declined through the pilot period (Figure 9).

Analyses also explored differences in buprenorphine initiation or continuation across racial groups, ethnicity, gender, and age. Analyses found that patients who initiated buprenorphine at SAFR had a lower median age compared to those who did not initiate buprenorphine (38 years versus 42 years: $p \leq 0.01$, $d = 0.31$).³

6. Over half of patients tested positive for opiates via UDS between March June. Data from January-February may be an undercount due to reporting gaps.

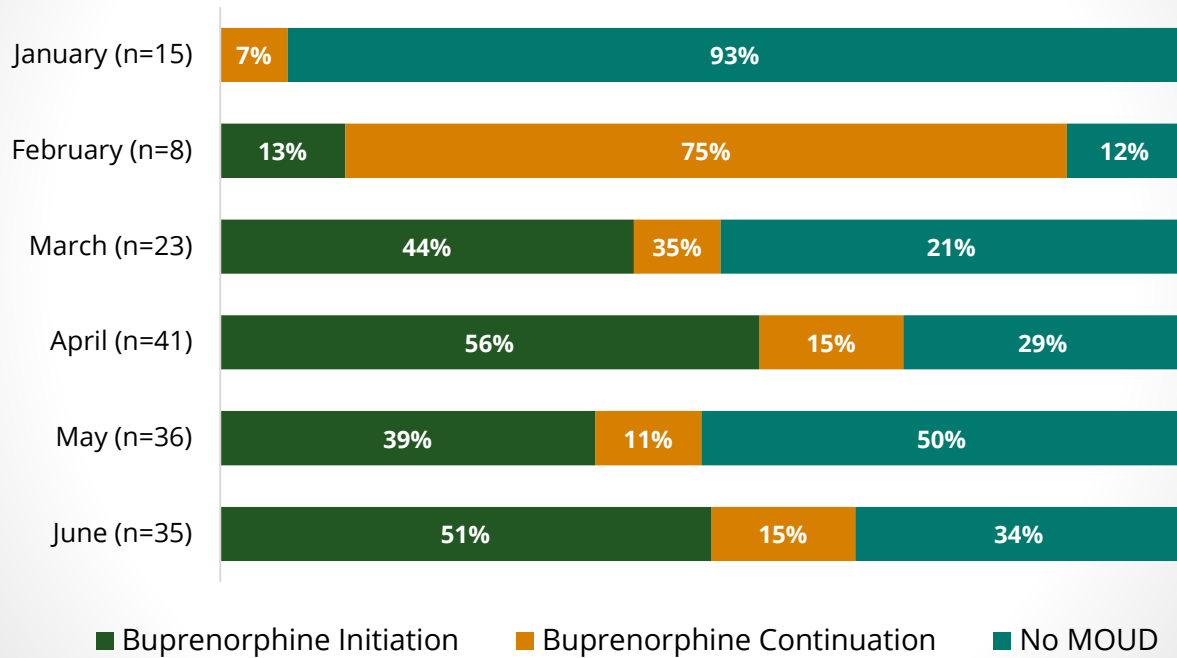


7. Fentanyl was the most commonly detected opiate via UDS (n=158).

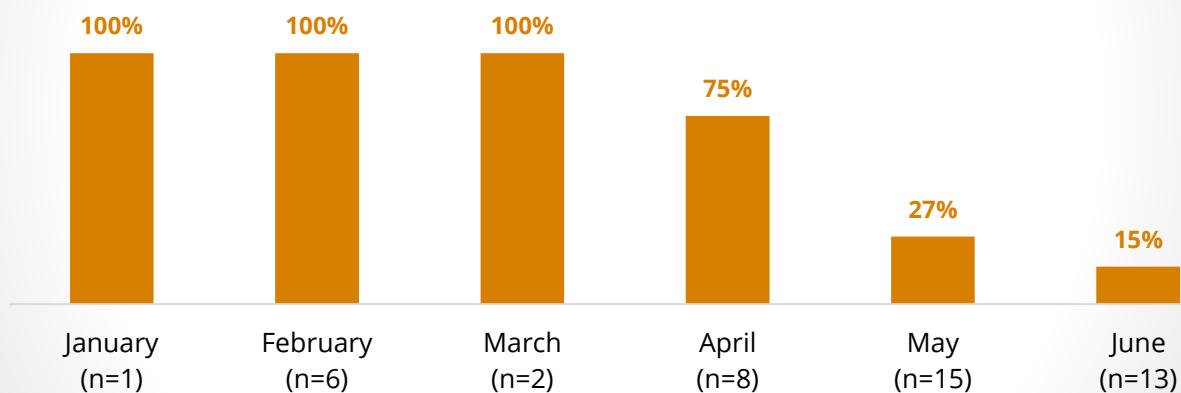


³ The Mann-Whitney U test was used to measure the difference in buprenorphine initiation and median age, The magnitude of difference was reported with Cohen's d by converting non-parametric effect sizes: small effect (0.15 - 0.44), medium effect (0.45 - 0.79), large effect (0.80+).

8. Among patients who screened positive for opiates via UDS, at least half either initiated or continued buprenorphine at the SAFR Center. Due to data gaps, it is unclear how many patients were provided with MOUD in January.



9. Continued MOUD treatment among patients testing positive for buprenorphine at SAFR declined from April to June. Although 100% of patients continued treatment from January-March, these rates reflect a small sample size.



Data Gaps. Between January to June, key data gaps have prevented a complete understanding of the extent to which Goal 1 has been met. The primary gaps summarized below are currently being addressed by CBI.

TRIAGE TIME. A large proportion of patients are internally transferred from CBI's 23-Hour Crisis Unit (73%); therefore, triage time may not be documented as part of the transition into the SAFR unit. Overall, 11% of patients had a documented triage time. Among these patients, the median triage time was 30 minutes, exceeding the target goal of 10 minutes. Further exploration is needed to identify factors impacting triage times for these patients.

PSYCHIATRIC EVALUATIONS. After admission into the SAFR Center, 64% of patients were documented as receiving a psychiatric evaluation. This gap is again likely due to patients' care pathway. Patients transferred internally from CBI's 23-Hour Crisis Unit receive a psychiatric evaluation during crisis care and these evaluations may not be connected to the documentation for their stay in the SAFR unit.

NALOXONE EDUCATION AND DISTRIBUTION. SAFR patients should receive naloxone overdose prevention medication and education. While SAFR staff have noted that this process is carried out by nursing staff, data documentation from the pilot period showed no patients recorded as receiving naloxone or education.

INCIDENTS

Between January to June, SAFR staff documented 41 incidents among 30 patients related to safety, elopement, and behavioral issues. The incidents included:

n=19

AGAINST MEDICAL ADVICE (AMA). Patient left or refused care against clinical advice.

n=4

INJURY. Physical harm to a patient, staff, or visitor on-site.

n=3

PHYSICAL ABUSE. Intentional physical harm inflicted by a patient.

n=3

CRISIS PREVENTION INTERVENTION (CPI) ADMINISTERED. CPI techniques were used to de-escalate patients.

n=3

CODE OF CONDUCT VIOLATION. Patient broke facility rules.

n=3

SUSPECTED CRIMINAL ACTIVITY. Behavior from patients that may violate the law.

n=2

REFUSAL OF SERVICES. Patient declined offered care.

n=1

PROPERTY DAMAGE/LOSS. Facility or personal property destroyed, stolen, or missing.

n=1

VIOLENCE/THREAT TOWARDS STAFF. Physical aggression or threats directed at staff.

n=1

MEDICAL ERROR WITH ADVERSE REACTION. Medication error that caused a negative patient reaction.

n=1

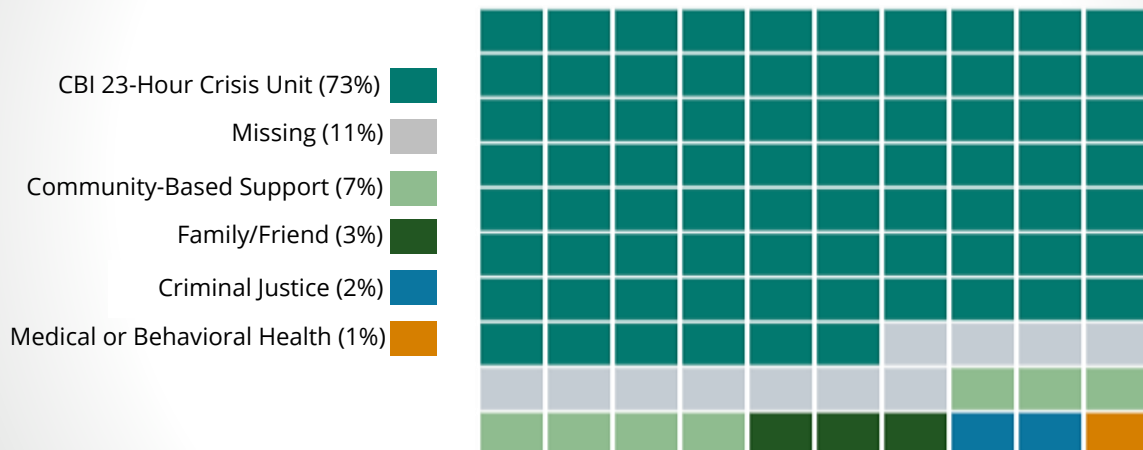
TRANSFER OF CARE. Patient's care was transferred to medical services.

SAFR Goal 2: Decrease law enforcement detentions, arrests, and jail bookings for non-violent, intoxication-related incidents.

The [National Sobering Collaborative's Standards of Care](#) encourage partnerships between sobering centers and law enforcement agencies as a key component of best practices (National Sobering Collective, 2023). Consistent with this recommendation, a report from the National Policing Institute found that law enforcement agencies view sobering centers as a valuable resource, primarily through saving officer time and resources, and providing a better alternative for intoxicated individuals than jail. The report also found that law enforcement was the most common referral source among 69% of 18 sobering facilities nationwide. Among these, nine facilities reported the proportion of admission referrals from law enforcement, which ranged between 1.6% and 95% of each facility's total referrals (Isaza, et al., 2022).

SAFR Center Intake Referrals. Between January to June, Criminal Justice referrals to the SAFR Center comprised a small percentage of all total referrals (**Figure 10**). Most Criminal Justice referrals were from the Tucson Police Department (TPD); two referrals came from Tucson City Court and Probation. Most referrals to the SAFR Center were internally transferred from CBI's 23-Hour Crisis Unit. However, patients brought to the SAFR Center by referral partners (e.g., Community-Based Support, Criminal Justice, and Medical/Behavioral Health agencies) may first be diverted to the 23-Hour Crisis Unit based on clinical need. When this occurs, the patient's referral to the SAFR Center is documented as an internal transfer from the 23-Hour Crisis unit rather than the original referral source. This may not accurately capture the number of direct referrals to the

10. Most patients (n=346) were internally transferred to the SAFR Center from CBI's 23-Hour Crisis Unit. Transfer information was missing for 11% of patients.



SAFR Center from external partners. Additionally, 11% of patient records did not indicate whether the patient was internally transferred from the 23-Hour Crisis Unit, further limiting interpretation of referral patterns. For these 11% of records, referral sources included Family/Friend (6%), Criminal Justice (3%), and Community-Based Support (2%).

Data Quality. Conversations with the TPD Community Outreach Resource and Education (CORE) team (**see page 18**) indicate that the department's internal estimate of monthly referrals is notably higher than what is reflected in SAFR's referral data. SAFR staff have noted no challenges with law enforcement-related data documentation at intake. However, the complexity of the referral pathway may contribute to the potential undercounting of TPD CORE referrals and jail deflections. Several factors may contribute to this discrepancy:

SHARED OUTREACH EFFORTS. SAFR staff noted that TPD CORE officers and community outreach teams often conduct outreach together. In some cases, TPD CORE may initiate the referral, while a community partner transports the patient to SAFR. Therefore, the original TPD CORE referral may not be captured.

TPD CO-RESPONDER REFERRALS. TPD co-responders (peer support specialists who conduct community outreach) may facilitate referrals to the SAFR Center. These referrals may not always be distinguished as TPD

referrals. Although a referral from a TPD co-responder is not considered to be a true deflection from jail, accurately capturing these counts would help understand the overall impact of TPD's partnership with the SAFR Center.

DROP-OFF PROCEDURES. SAFR staff also noted that TPD CORE officers may drop patients off outside the intake lobby. As a result, TPD CORE may not be present during intake as the documented referring source.

Reconciling these data gaps will help understand if the SAFR Center meets the goal of decreasing law enforcement detentions, arrests, and jail bookings for non-violent, intoxication-related incidents.

TPD Surveys. Following patient drop-off, officers can complete a brief survey (**Appendix C**) regarding their experience with the intake process at the SAFR Center. Between January to June, only three surveys were completed. All respondents indicated that the SAFR Center was available for immediate access, intake staff were professional and courteous, and that the patient would have been brought to jail if SAFR wasn't available. Several factors may have contributed to low TPD survey completion. As noted previously, TPD officers may not always be present with patients at intake. Additionally, conversations with TPD CORE suggest that they may not be aware of the surveys or the expectation to complete one with every drop off, particularly in cases when they are not offered a survey by intake staff.

TPD CORE Team Feedback. Feedback from the TPD CORE team affirmed SAFR's value beyond deflection. They also recommended several enhancements related to access, intake, and partnership communication. The themes highlighted below were drawn from a feedback meeting with the TPD CORE unit on June 30, 2026. The findings reflect group discussion during the meeting and quotes were captured through notetaking, as close to verbatim as possible.

1 SAFR OFFERS VALUE BEYOND DEFLECTION

- SAFR accepts pets, which matters a great deal to many of the people that the CORE unit serves.
- SAFR's hours of operation and ability to accept almost anyone makes it more accessible than many shelters, especially later in the day.
- A meal, a shower, and a bed can be an important motivator when people are considering coming to SAFR.
- Officers rarely learn what happens after drop-off but described bringing individuals who demonstrate they are ready to make a change in their lives.

ELIGIBILITY QUESTIONS REMAIN

- Certain eligibility criteria seem to have shifted over time without notice, undercutting commitments officers may make to people in the field about what to expect at SAFR.
- Individuals have been routed through CBI's 23-Hour Crisis Unit after being told by CORE that they were headed directly to the SAFR unit.
- Pet policy is applied inconsistently, and PACC vaccine hours may leave an early-day gap for pet-owning patients seeking to come to SAFR.

INTAKE PRACTICES COULD BE ENHANCED

- The intake space can feel institutional; a snack, a drink, and a TV in the waiting area were suggested as small, low-cost changes to help people feel welcome and cared for immediately upon arrival.
- Several CBI staff were mentioned by name who model the care that CORE suggested could be enhanced center-wide to create a warmer experience for people while they wait for care.

PARTNERSHIP & DATA GAPS PERSIST

- The CORE unit's internal drop-off estimates are higher than CBI's monthly referral data, resulting in data discrepancies that obscure the center's true deflection impact.
- Few unit members were familiar with CBI's law enforcement drop-off surveys, which would be another potential data triangulation source for deflection counts.
- CORE offered to provide co-learning experiences and ride-along opportunities to build more regular contact and collaboration with CBI.

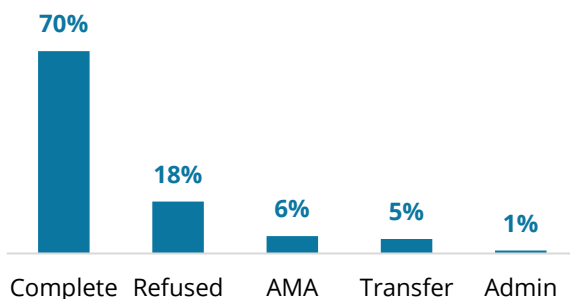
SAFR Goal 3: Mitigate the long-term negative consequences of criminalization by preventing criminal records and reducing barriers to housing, employment, and social services for individuals diverted from the criminal justice system.

According to the [National Sobering Collaborative's Standards of Care](#), a core benefit of sobering care is the opportunity for individuals to connect with community resources, facilitated by sobering facility staff. Specifically, the standards encourage direct care transitions into community resources including shelter or housing, substance use treatment, harm reduction services, mental health, and medical services (National Sobering Collective, 2023).

Patient Discharge and Referrals. Patients are discharged from the SAFR Center after completing their care or leave early due to refusal of services, AMA, administrative (admin) reasons, or transfer to another level of care. Between January to June, most patients had a complete discharge from the SAFR Center (**Figure 11**).

11. Most patients had a complete discharge at the SAFR Center (n=344).

Two patients did not have a documented discharge type.



For patients with a complete discharge, most were provided with treatment referrals to other CBI clinics (**Figure 12**), primarily for outpatient services.⁴ For the 12% of patients with a documented treatment referral as Family/Friend, CBI staff noted that the patient did not have a treatment referral in place at the time of discharge. Throughout the pilot period, referrals to Medical and Behavioral Health agencies increased, primarily to CODAC. (**Figure 13**). This pattern may indicate the positive impact of CODAC's subcontracted patient navigator in helping patients transition to ongoing care.

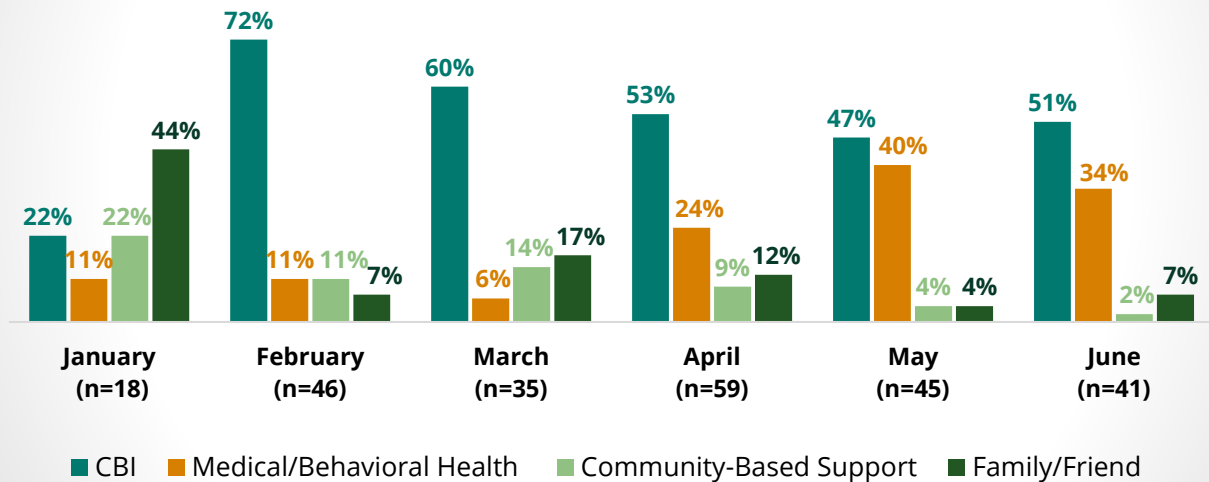
Placement referrals were primarily to Family/Friends and Community-Based Support organizations, though referrals to Medical and Behavioral Health agencies steadily increased (**Figure 14 and Figure 15**).⁵

Transportation. To help ensure a warm-handoff and coordination of care to referral partners, patients were offered transportation from the SAFR Center when needed and available. Transportation data has been collected since April; since then, 45 transportation trips were provided for 22 patients.

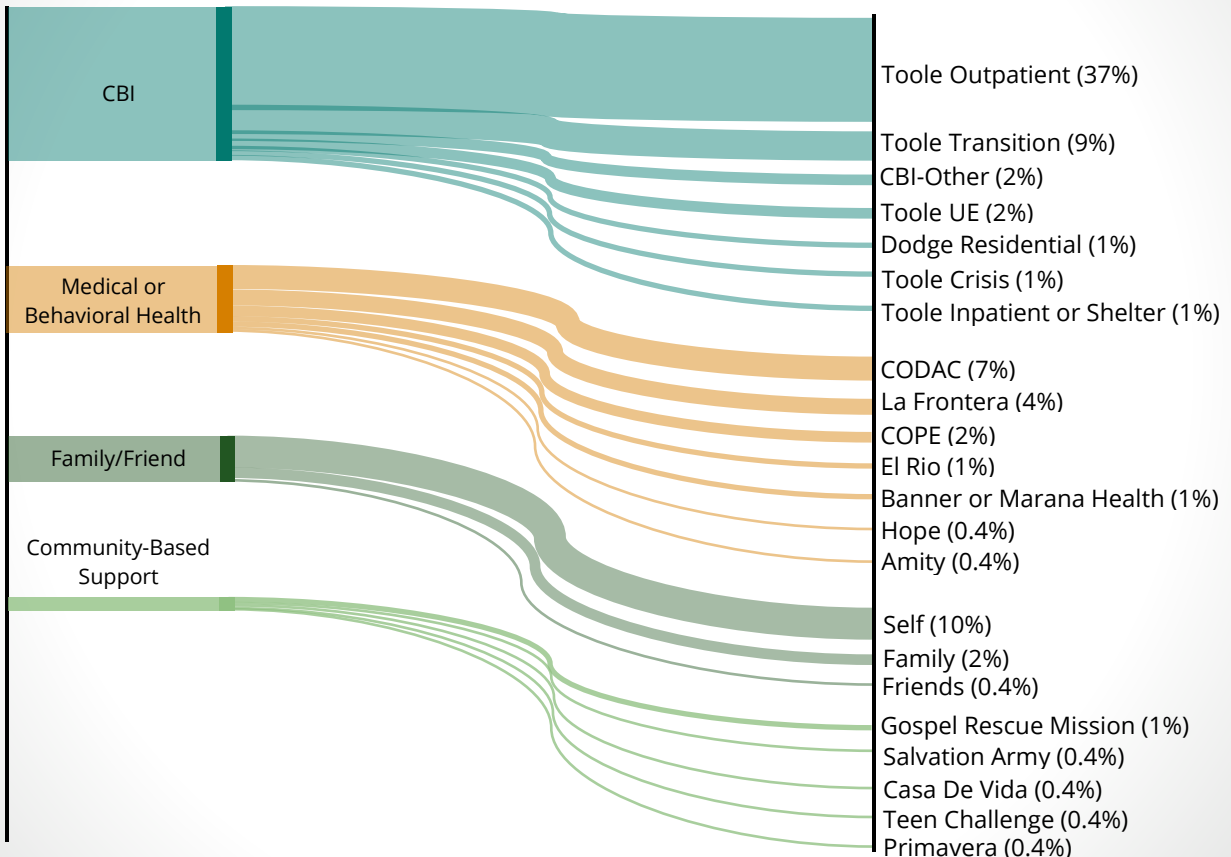
⁴ Treatment referrals connect patients to treatment services, such as for substance use.

⁵ Placement referrals connect patients to the next place they will stay, such as with a family member or friend, shelter, or residential treatment facility.

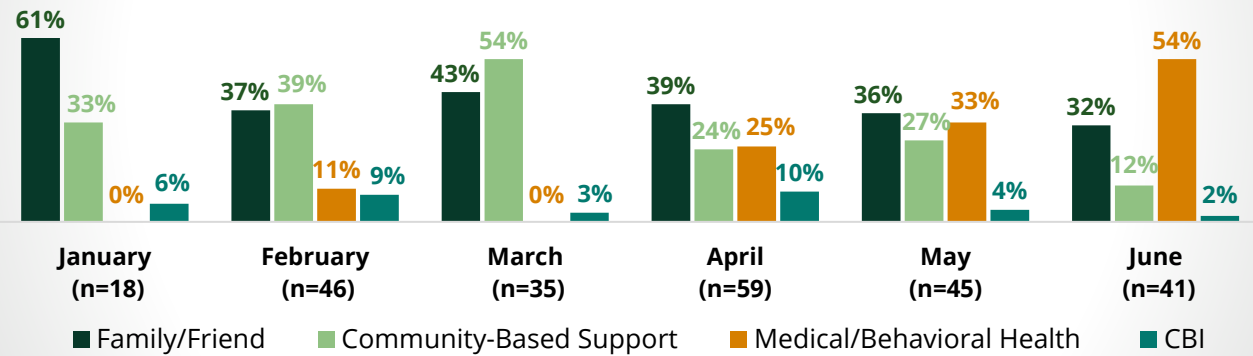
12. For patients with a complete discharge, treatment referrals were primarily provided to CBI clinics. Referrals to Family/Friend indicate that patients did not have a treatment referral at the time of discharge.



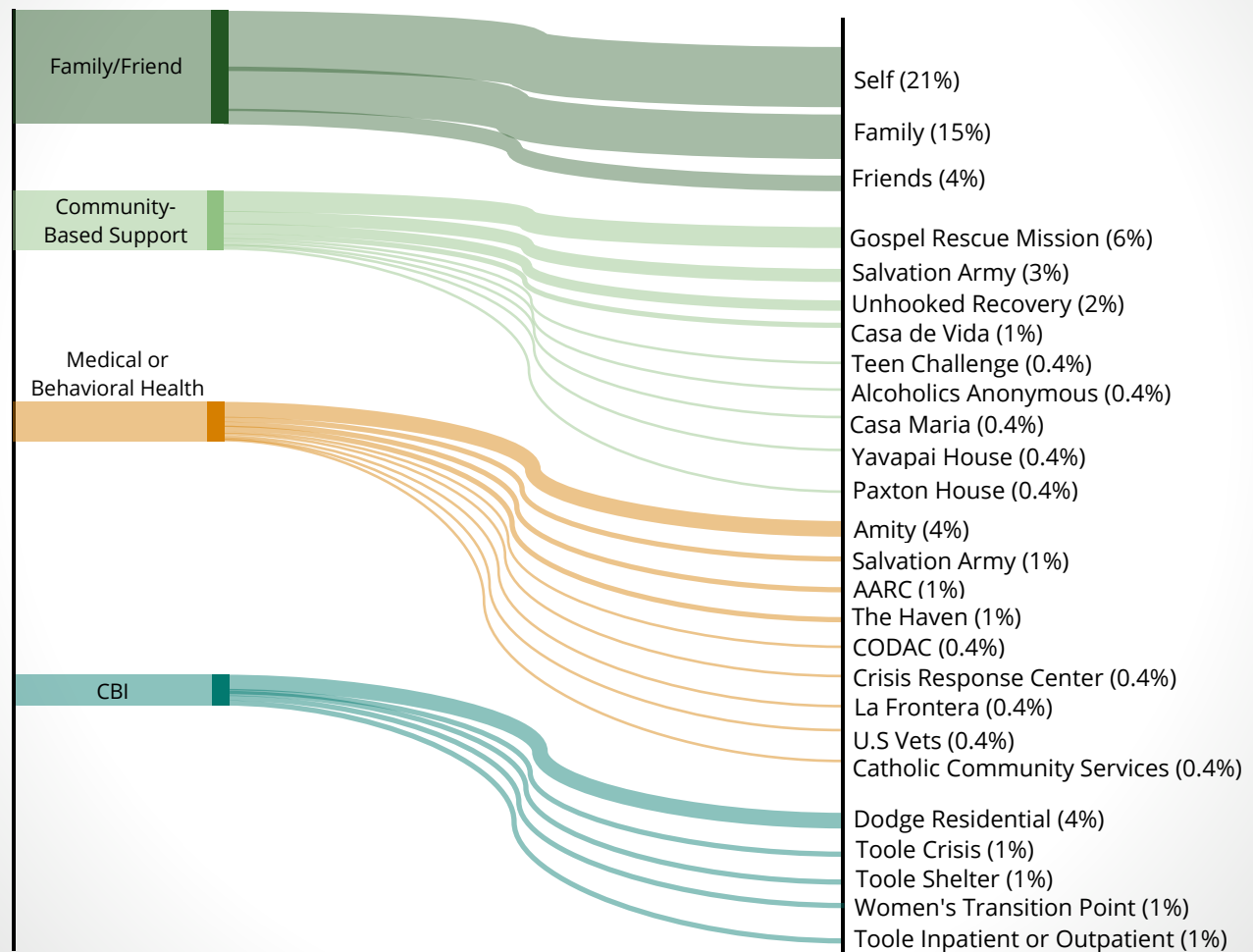
13. Over a third of all patients with a complete discharge were referred to treatment at CBI's Outpatient Clinic. About 13% of referrals were categorized as "Other" within Medical or Behavioral Health and Community-Based Support referrals (not shown).



14. For patients with a complete discharge, placement referrals were primarily to Family/Friends or Community-Based Support, though referrals to Medical or Behavioral Health agencies peaked in June. Referrals to a shelter comprised a small percentage of referrals in February and April (<2%).



15. Over a third of all patients with a complete discharge were referred placements with Self or Family. About 28% of referrals were categorized as "Other" within Behavioral Health and Community-Based Support referrals (not shown).



CODAC Enrollment. Since April, CODAC has provided on-site patient navigation and discharge continuity services as a subcontractor. In that time, 19 patients continued care at CODAC; 12 of those patients were new to CODAC's services.

30-60-90- DAY TREATMENT ENGAGEMENT. Six patients received CODAC services including outpatient visits, telehealth appointments, and mental health support. Four of these patients started services within the first 30 days of referral. Two began between days 31 and 60. One patient stayed engaged with services through 90 days.

MOUD INDUCTION. Among the six patients who received services at CODAC, four patients initiated MOUD treatment. Specifically, three patients were provided Suboxone and one received methadone.

30-60-90- DAY MOUD ENGAGEMENT. All four patients who initiated MOUD remained active at 30-days; three patients remained active at the 60-day mark; and two patients remained active by the 90-day mark.

*"A woman had been living on the street doing drugs and got diverted to SAFR. I got in touch with her case manager and let them know she was at CBI. We got her restarted on Suboxone and placed at The Haven. **I see her at CODAC now. She has been coming back for medication reviews and appointments.**"*

-CODAC's On-site SAFR Patient Navigator

HEALTHCARE UTILIZATION. Five patients accessed crisis, emergency, or hospital services a combined sixteen times, with ten encounters occurring within the first 30-day interval and six within days 31 and 60.

LAW ENFORCEMENT CONTACT. Nine patients had an encounter with law enforcement within the 30-day interval period. All nine of these patients were unhoused.

*"There was [someone] on court-ordered treatment. He is elderly and comes to CBI a lot. I was asked to take him to get his court-ordered mental health treatment. Just by giving him a ride to get his treatment, **we were keeping him out of [crisis] where he would take up a bed for a few days, keeping him away from using police resources, keeping him mentally stable - just by giving him transport.**"*

-CODAC's On-site SAFR Patient Navigator

CODAC'S PATIENT NAVIGATOR SUPPORTS PATIENTS THROUGHOUT AND BEYOND THEIR SAFR STAY:



PRESENCE AT THE SAFR CENTER. CODAC's patient navigator provides a daily presence: checking in with patients on needed services, updating charts, and serving as a patient advocate regardless of CODAC enrollment status. This constant presence builds trust with patients.



SERVICE CONNECTION. For patients without an existing provider, the patient navigator discusses CODAC's integrated services, including mental health services which was identified as a highly desired need among patients. Interested patients are enrolled in CODAC at the SAFR Center with the assistance of the navigator, reducing barriers related to transportation and wait times.



POST-SAFR DISCHARGE. The patient navigator is a post-discharge touchpoint, serving as a familiar source for accessing substance use treatment, seeing a doctor, and/or accessing mental health services, thereby reducing follow-through barriers.

Barriers to Ongoing Care. CODAC's on site patient navigator reported that most patients' unhoused status, compounded by several additional intersecting challenges, makes tracking patients post-discharge difficult:

EXPOSURE TO SUBSTANCE USE. Patients' elevated exposure to substance use in the community drives hesitancy to engage in treatment after leaving the SAFR Center. CODAC's clinic location, near First Avenue and Fort Lowell Road, is an area with high drug activity, compounding temptation for patients.

PHONE ACCESS. Free phone programs have largely disappeared, and unhoused patients frequently have their phones stolen, cutting off a key communication channel with CODAC. Readmission to the SAFR Center is currently the most reliable way to reconnect with patients who've been lost to follow-up.

TRANSPORTATION. Flexibility for CODAC staff to offer transportation to its members is currently a facilitator for ongoing care as well as a barrier, constrained by the agency's current transportation policies.

*"There are some folks who apply for AHCCCS and sometimes there is a snag in application process, like they need an extra form. Patients have to keep waiting [at SAFR] to get placed somewhere else. CODAC has someone whose entire job is to handle AHCCCS applications. So, **I can transport patients to CODAC, they get help with their application, and then they can get placed [into treatment].**"*

-CODAC's On-site SAFR Patient Navigator

CBI Staff Reported Progress to Date on Quality Improvement (QI) Domains Identified in the SAFR Midpoint Report. The themes highlighted below were drawn from meetings and feedback sessions with CBI staff between April and July 2026. The findings reflect group discussions during these meetings and quotes were captured through notetaking, as close to verbatim as possible.



PET SUPPORT: Progress supporting pets has included completion of the outdoor dog run (see **page 11** for additional highlights). Limited vaccination hours and post-discharge pet-friendly treatment options remain challenging.



PATIENT EXPERIENCE: In July, CBI ordered sound reducing panels. CBI has also contracted with an outside firm to identify and install additional enhancements to the aesthetic environment, such as murals.



OVERSIGHT & COORDINATION: CBI is hiring a SAFR-specific role to lead overarching program management and has provided an organizational chart to support communication coordination and accountability.



DATA QUALITY: As described throughout the report, data quality gaps impact analysis and interpretation of progress on SAFR's goals. CBI has implemented additional training protocols and data collection and reporting processes.



PARTNER COMMUNICATION: In July, CBI initiated a working group with community partners to enhance communication and coordination. A trifold brochure is also in progress to market key SAFR information.



STAFFING: Most positions including peer support specialist roles are filled, and SAFR now has a CODAC patient navigator onsite for continuity of care. Several other positions are still to be hired.

*"From an operations perspective, we've worked through a lot of [challenges]. There's been more clarification of the intake process, how quickly patients are seeing providers, getting pets the arrangements to get vaccinated. **The entire flow from door to discharge and referrals - all of these processes have been working more effectively.**"*

-SAFR On-Site Supervisor

Recommendations

Progress to Date on Midpoint Report Recommendations.

STAFFING

1. **Complete staffing and consider a dedicated benefits enrollment specialist.**
☐ **IN PROGRESS:** All peer support specialist roles have been filled. A SAFR-dedicated program manager hire is in progress. A clinician, clinical manager, and patient technician position are still to be hired.

DATA & DOCUMENTATION

2. **Strengthen documentation practices.**
☐ **IN PROGRESS:** While data quality gaps remain, CBI continues to adopt enhancements to SAFR's data and reporting processes, including additional staff trainings.
3. **Standardize TPD referral tracking to accurately measure deflections.**
☐ **PARTIALLY MET:** CBI is updating their EHR system for more precise intake reporting, including fields for outreach teams and co-responder staff. Deflection tracking via TPD drop-off surveys remains limited. CBI is seeking additional support from TPD leadership to encourage survey completions.
4. **Enhance MOUD initiation capacity and OUD metric tracking.**
☒ **ACHIEVED:** At least half of patients who screened positive for opioids at intake initiated or continued buprenorphine. SAFR now offers post-discharge MOUD services for applicable patients through a subcontract with CODAC.

PATIENT CARE

5. **Integrate PRAPARE data into individualized patient care planning.**
☐ **PARTIALLY MET:** CBI staff reported a variety of ways in which patients' SDoH have been considered during discharge planning. Currently, there is no mechanism to document how and to what extent patients' social needs are systematically integrated into their treatment and social service referrals.

6.	Address transportation as a needed support. ☐ PARTIALLY MET: Monthly reports summarizing patient transportation by SAFR staff from the SAFR Center to community partners were generated starting in April. There is no current reporting mechanism for patient transportation to SAFR provided by SAFR staff or community partners.
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7.	Track patient incident patterns over time. ☒ ACHIEVED: While 25 patient incidents were reported in the first two months of operation, only 16 were logged in the subsequent 3 months. AMA patient departures were the most common reason an incident was reported.
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COMMUNITY PARTNERSHIPS

8.	Establish a formalized partner communication strategy. ☐ IN PROGRESS: CBI has initiated a SAFR communications working group with community partners, and tailored trifold brochures are in development to market the center's key information and guidelines.
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Endpoint Report Recommendations.

DATA & DOCUMENTATION

- 1. Strengthen intake referral reporting in collaboration with TPD's CORE unit.**
Implement additional coordination with the CORE unit to share referral metrics or develop unified metrics across both agencies. These processes would support enhanced data accuracy to measure progress towards SAFR's deflection goal.

PATIENT CARE

- 2. Strengthen referral reporting for patients not entering treatment.**
The treatment referral category Family/Friend was used for 12% of complete discharges and 18% of all discharges since January, and typically represents patients discharged without a verified treatment referral. More accurate documentation of these discharges would more clearly depict the post-SAFR care pathways and gaps for SAFR patients.
- 3. Explore additional care options for patients with pets.**
Treatment referral options for patients with pets remain limited. Exploring additional options for these patients, including whether CBI could accept pets within its internal referral system (using the SAFR Center as a model), could enhance continuity of care for these patients.
- 4. Address post-discharge continuity of care challenges.**
Early data on CODAC's longer term SAFR patient outcomes indicate that significant barriers persist for patients after their SAFR stay. Continued attention to wraparound care during the crucial months post-discharge may increase the number of SAFR patients who access services such as MOUD, housing, and/or employment support.

COMMUNITY PARTNERSHIPS

- 5. Explore additional intake and treatment referral opportunities.**
Most SAFR patients are enrolled from within CBI's 23-Hour Crisis Unit, and at discharge, most are referred to CBI's internal treatment network. Expanding the number and variety of community partners that refer patients to SAFR will maximize the likelihood that every individual needing sobering care has access to the SAFR Center. Similarly, expanding the discharge referral network can ensure that SAFR patients have access to treatment from the largest network of available resources.

Conclusion: The Year Ahead

Across six months, the SAFR Center moved from an accelerated launch to a program with a clearer operational rhythm.

The addition of CODAC's onsite patient navigator in April offered an early window into what happens after discharge, a question the [Midpoint Report](#) could not yet answer. Nineteen patients continued care at CODAC in the pilot's second half, and most who initiated MOUD there remained engaged at 30 and 60 days. These are small numbers from a narrow tracking window, better read as a starting point than a settled finding.

Patient satisfaction remained consistently high, and patient feedback continued to describe the SAFR Center as a place where many felt cared for, fed, and safe.

The structural gaps identified at midpoint have not fully closed. TPD referral tracking remains inconsistent, limiting the program's ability to demonstrate its deflection impact. Post-discharge continuity, particularly for patients without stable housing, phone access, or pet-friendly treatment options, is challenging. Enhancements to staffing, documentation, and formal partner communication remain in progress.

The recommendations accompanying this report point to where work is most needed: data coordination with law enforcement partners, clearer post-discharge referral documentation, a broader referral network, and continuity of care for patients with pets.

The Pima County Board of Supervisors' decision to extend SAFR Center funding for an additional year gives the program time to address SAFR's challenges, which are likely to be additionally supported by the hiring of the SAFR Center's remaining staffing positions.

The SAFR Center was built on the premise that people in crisis deserve a more effective and dignified response than jail or the emergency department. Six months of data suggest the program is growing and evolving toward the goal of delivering that response, all while providing quality care to patients in real time. Continuing to enhance operations and demonstrating longer term outcomes, as well as progress toward addressing SAFR's final goal - to reduce burden on the emergency room and EMS systems - will be essential to the work in the year ahead.

*"SAFR tries to open doors to patients with no other options. For example, patients with a stimulant use disorder only don't qualify at a lot of treatment centers. Patients with pets can't get in anywhere, and animals are all they have. **SAFR opens a lot of doors to treatment for anyone, in a safe place.**"*

-SAFR Center Operations Manager

References

- Isaza, G., Enfel, R., Cherkauskas, J. (2022). *Examining the Utility of Sobering Centers: National Survey of Police Departments and Sobering Centers*. National Policing Institute. https://www.policinginstitute.org/wp-content/uploads/2022/12/Evaluating-the-Utility-of-Sobering-Centers_National-Survey-Report_FINAL.pdf
- National Sobering Collective. (2023). *Recommended Standards for Sobering Care for Alcohol and/or Other Drug Intoxication*. https://nationalsobering.org/wp-content/uploads/2023/10/StandardsofCare_Sobering_PUBLIC_2023-10.pdf

Appendix A.

The Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences (PRAPARE) Tool

The PRAPARE is a national, evidence-based, standardized patient risk assessment tool designed to identify and address social determinants of health (SDoH).



Protocol for Responding to and Assessing
Patients' Assets, Risks, and Experiences

PRAPARE®: Protocol for Responding to and Assessing Patient Assets, Risks, and Experiences
Paper Version of PRAPARE® for Implementation as of September 2, 2016

Personal Characteristics

1. Are you Hispanic or Latino?

☐	Yes	☐	No	☐	I choose not to answer this question
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2. Which race(s) are you? Check all that apply

☐	Asian	☐	Native Hawaiian
☐	Pacific Islander	☐	Black/African American
☐	White	☐	American Indian/Alaskan Native
☐	Other (please write):		
☐	I choose not to answer this question		

3. At any point in the past 2 years, has season or migrant farm work been your or your family's main source of income?

☐	Yes	☐	No	☐	I choose not to answer this question
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4. Have you been discharged from the armed forces of the United States?

☐	Yes	☐	No	☐	I choose not to answer this question
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5. What language are you most comfortable speaking?

Family & Home

6. How many family members, including yourself, do you currently live with? _____

☐	I choose not to answer this question
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7. What is your housing situation today?

☐	I have housing
☐	I do not have housing (staying with others, in a hotel, in a shelter, living outside on the street, on a beach, in a car, or in a park)
☐	I choose not to answer this question

8. Are you worried about losing your housing?

☐	Yes	☐	No	☐	I choose not to answer this question
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9. What address do you live at?

Street: _____

City, State, Zip code: _____

Money & Resources

10. What is the highest level of school that you have finished?

☐	Less than high school degree	☐	High school diploma or GED
☐	More than high school	☐	I choose not to answer this question

11. What is your current work situation?

☐	Unemployed	☐	Part-time or temporary work	☐	Full-time work
☐	Otherwise unemployed but not seeking work (ex: student, retired, disabled, unpaid primary care giver) Please write:				
☐	I choose not to answer this question				

12. What is your main insurance?

☐	None/uninsured	☐	Medicaid
☐	CHIP Medicaid	☐	Medicare
☐	Other public insurance (not CHIP)	☐	Other Public Insurance (CHIP)
☐	Private Insurance	☐	

13. During the past year, what was the total combined income for you and the family members you live with? This information will help us determine if you are eligible for any benefits.

☐	I choose not to answer this question
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Protocol for Responding to and Assessing
Patients' Assets, Risks, and Experiences

PRAPARE®: Protocol for Responding to and Assessing Patient Assets, Risks, and Experiences
Paper Version of PRAPARE® for Implementation as of September 2, 2016

14. In the past year, have you or any family members you live with been **unable** to get any of the following when it was **really needed**? Check all that apply.

Yes	No	Food	Yes	No	Clothing
Yes	No	Utilities	Yes	No	Child Care
Yes	No	Medicine or Any Health Care (Medical, Dental, Mental Health, Vision)			
Yes	No	Phone	Yes	No	Other (please write):
I choose not to answer this question					

15. Has lack of transportation kept you from medical appointments, meetings, work, or from getting things needed for daily living? Check all that apply.

Yes, it has kept me from medical appointments or
Yes, it has kept me from non-medical meetings, appointments, work, or from getting things that I need
No
I choose not to answer this question

Social and Emotional Health

16. How often do you see or talk to people that you care about and feel close to? (For example: talking to friends on the phone, visiting friends or family, going to church or club meetings)

Less than once a	1 or 2 times a week
3 to 5 times a week	5 or more times a
I choose not to answer this question	

17. Stress is when someone feels tense, nervous, anxious, or can't sleep at night because their mind is troubled. How stressed are you?

Not at all	A little bit
Somewhat	Quite a bit
Very much	I choose not to answer this question

Optional Additional Questions

18. In the past year, have you spent more than 2 nights in a row in a jail, prison, detention center, or juvenile correctional facility?

Yes	No	I choose not to answer this
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19. Are you a refugee?

Yes	No	I choose not to answer this
-----	----	-----------------------------

20. Do you feel physically and emotionally safe where you currently live?

Yes	No	Unsure
I choose not to answer this question		

21. In the past year, have you been afraid of your partner or ex-partner?

Yes	No	Unsure
I have not had a partner in the past year		
I choose not to answer this question		

Appendix B. CBI Patient Survey

The Patient Survey was developed by CBI and is offered to SAFR patients at the time of discharge.



Patient Survey

YOUR OPINION MATTERS TO US

Date: _____ **Facility:** **EVARC Crisis**

What did you like best about your CBI experience?

Rating Scale: (5) Excellent (4) Very Good (3) Good (2) Fair (1) Poor	5	4	3	2	1
How satisfied were you with the cleanliness and appearance of the facility?					
How satisfied were you with the overall care you received?					
How satisfied were you with your staff experiences?					
How satisfied were you with your medical practitioner experience?					
How satisfied were you with your discharge plan?					
How likely are you to recommend our services to a family or friend who is in crisis?					

Appendix C. CBI Police Officer Survey

The Police Officer Survey was developed by CBI and is offered to Police Officers at the time of patient drop off.



Date _____

Time _____

Facility: _____

Dept: _____

	Rating Scale: Yes (Y), No (N)	Yes	No
1	Was the facility available for immediate access?		
2	Did staff assist you quickly?		
3	Were staff professional and courteous?		
4	Are you a CIT certified officer?		
5	Would you have brought this person to jail if this facility wasn't available?		

Thank you. We appreciate your feedback. Please provide any additional comments, if applicable.
